Medicaid and Public Health Partnership Learning Series

Health Homes

CONTENTS

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OVERVIEW

While working to reduce the incidence of chronic conditions, Medicaid and public health agencies have noticed a growing interest in the application and use of health homes in Medicaid to deliver person-centered, preventive care. Health homes are a care delivery model in which participants have their care coordinated across the array of healthcare services, and often states use this model for individuals with significant healthcare needs. Medicaid agencies have the option to receive time-limited, enhanced federal funding to implement one or more health home programs through which states can provide a health home for certain Medicaid beneficiaries with chronic conditions. This funding is available for two years for programs that serve beneficiaries who have one chronic condition and are at risk for a second, those with two or more chronic conditions, or individuals with a serious and persistent mental illness. Services under this model include care management, care coordination, health promotion, transitional care and follow-up, patient and family support, and referral to community and social supports.

In order for states to implement a health home program, they must design the program, submit and receive CMS approval of a state plan amendment (SPA), and revise their cost allocation plan.

OPPORTUNITIES FOR PUBLIC HEALTH

When a state designs a health home program, there may be opportunities for the state public health agency to collaborate with Medicaid to achieve common health outcome goals. Some of these collaborative efforts include:

- Helping to identify key populations and health targets for the health home program through public health surveillance data.
- Supporting health home requirements to provide services and referral to community and social supports. Public health agencies have first-hand knowledge of community supports and can help shape this aspect of the health home program.
- Exploring ways to enhance the provision of clinical preventive services in health homes and facilitating the use of existing public health preventive and early intervention programs for the Medicaid population as part of the program.
- Where appropriate, assisting local health agencies in becoming the health homes that will coordinate and be the center of patients' care under this model. Depending on the program's population and shape, local health agencies may be well positioned to fill this role, with support from the state health department.
- Assisting with outreach efforts to target populations for health home programs by leveraging existing relationships.
- Collaborating with Medicaid to determine the most appropriate goals and outcome measures for the health home program. Public health agencies may also provide analytic expertise to help measure and evaluate the success of the health homes and the overall program.
- Engaging with Medicaid managed care organizations (MCOs) that operate health home programs and helping them make changes to their beneficiaries' environments to improve health outcomes.

KEY ISSUES

To prepare for a thoughtful interagency conversation on the use of health homes, it is helpful for public health agencies to have baseline information about the Medicaid policy issues that are foundational to the use of this model. The following factsheet explores these key issues and is intended to inform interagency dialogue about health home programs. To determine if a state is currently planning or has implemented a health home program, please visit their state's Medicaid website or see CMS' map of health home activity (available at the CMS Health Home Information Resource Center.)

State Plan and State Plan Amendments

A Medicaid state plan is the contract between CMS and the state to administrate the Medicaid program. It specifies how states will carry out program operations and discusses any additional optional program features that states have elected to include. If a state wants to make changes to a Medicaid program, such as receiving enhanced funding for health home services, it must submit a SPA to CMS for review and approval. For the health home option, CMS has developed a template SPA to support states in the planning and design process (available at the CMS Health Home Information Resource Center.)

States use SPAs to make changes to a Medicaid program within current law, such as adding an optional eligibility group or service to the program, while a waiver must be used when a Medicaid agency wants to make a change to the program that is not in accordance with federal law. Though SPAs require CMS review and approval, and require significant planning by the state, they are the least burdensome approach to amend a state Medicaid program. Waivers, especially Section 1115 waivers, involve a much more intensive planning, review, and approval process on the part of the Medicaid agency.

Federal Medical Assistance Percentage

Medicaid is financed jointly by the federal and state governments. The share of funding provided by the federal government is called the federal medical assistance percentage (FMAP), often referred to as the matching rate. States pay for their share of Medicaid program costs and these dollars are matched by federal funding. The amount of federal funding depends on the state's FMAP, which varies based on a state's average per capita income, but is never less than 50 percent. A 50 percent matching rate means that for every state dollar, the federal government also provides a dollar for the state's program. State-by-state information on matching rates is available here.

Federal lawmakers have increased the matching rate to support and encourage states to implement health homes. A 90 percent FMAP is available for health home services for two years under an approved SPA. Since the increased FMAP is time limited, states must think about how to design a health home program that is sustainable after the 90 percent matching rate ends and how the program is funded at the state's normal matching rate.

Managed Care and Fee-for-Service

Medicaid programs typically deliver healthcare services through a fee-for-service or managed care model. Under a Medicaid fee-for-service model, the state agency pays providers directly for services they deliver to a Medicaid beneficiary. Under the Medicaid managed care model, the state contracts with private health plans, Managed Care Organizations (MCOs), to deliver some or all healthcare services to Medicaid beneficiaries.[i] Managed care arrangements are typically risk-based, meaning that the state pays a set fee, or capitation rate, per enrollee to a private health plan for the delivery of services to that individual. The health plan is responsible for contracting with and paying individual providers for the provision of care. States may exclusively use a fee-for-service model or a managed care approach, or they may deliver care to different segments of beneficiaries with some combination of both models. For example, children and pregnant women may be covered through managed care, while disabled individuals receive fee-for-service care through Medicaid. (For information on the delivery models used by each state, visit the state's Medicaid agency website.)

States may implement health homes using a fee-for-service or managed care model, but the structure of the program will differ. In fee-for-service programs, the state will implement the model directly and will set up the reimbursement structure for entities that serve as the health home. In managed care, Medicaid agencies will work through the contracting process with MCOs to institute the model. As a result, Medicaid payment for the health home services must be folded into the capitation rate that each health plan receives for covering beneficiaries.

In states that have both managed care and fee-for-service Medicaid, the state may have to structure health home programs differently depending on the health condition or population it addresses. Consider, for example, a state that provides behavioral health services on a fee-for-service basis but uses managed care for physical healthcare needs. In this state, a behavioral health home could be implemented directly with providers, because it operates under the fee-for-service system, while a health home program for diabetes would require the agency to negotiate with health plans as these services are delivered through managed care.

[i] For additional information about different types of managed care programs, see "Report to the Congress: The Evolution of Managed Care in Medicaid," MACPAC, June 2011. Available at https://www.macpac.gov/publication/.

Key Issues

Managed Care Contracts

A managed care contract is the agreement between the state and the MCO that allows the MCO to deliver services to program enrollees. These contracts must be reviewed and approved by CMS, in addition, they represent the primary vehicle for the state to hold its plans accountable. They are also the primary vehicle through which states drive improvement in the delivery of care under a managed care delivery model.

To implement a health home program through the contracting process, a state must include the program in the request for proposals (RFP). The RFP solicits health plans to serve the program's beneficiaries, outlines the roles and responsibilities of the health plan, and serves as the basis for the contract. States typically produce an RFP and contract with health plans every three to five years. Consequently, the timing of any new health home initiative must be tied to the timing of the contracting process.

Nevertheless, MCOs may be willing to work with public health agencies outside of the contracting process. MCOs have a degree of independence and are often directed by the Medicaid agency to drive quality improvement and care coordination efforts within the broad authority of the contract. As a result, plans may be interested in implementing innovative efforts, such as a health home program, even if the health home program is not a mandatory part of the contract with the state.

Cost Allocation Plans

To receive federal matching funds for administrative expenses in Medicaid, states are required to submit a cost allocation plan (CAP) to CMS. A CAP must describe how the state will identify and measure administrative expenses, for example a time study. The complex calculations that are part of a CAP are very challenging and require significant time and effort by the agency. If an activity benefits multiple programs, for example, the costs must be allocated based on the activities' relative benefits to each program and cannot be allocated to one primary program.

Administrative expenses include planning activities for a health home program. Therefore, to receive federal funding to design a health home program, states have to amend their CAPs to reflect this planning work. If public health officials are participating in the health home planning or it is benefiting public health agency initiatives or programs, this raises additional challenges around the already-complex CAP calculations. In particular, the public health agency, or other participating agencies or programs, will have to contribute its own funding to support its share of the administrative expenses.

RESOURCES

The following resources provide additional information on the health home model and explore other Medicaid issues that are relevant to a robust understanding of this care delivery approach.

- **"Report to the Congress: The Evolution of Managed Care in Medicaid."** Medicaid and CHIP Payment and Access Commission (MACPAC). June 2011. https://www.macpac.gov/publication/.
  Provides additional information on the different types of managed care programs.

- **Health Home Information Resource Center.** Centers for Medicare and Medicaid Services. http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.
  Includes links to the state health home SPAs and a health home SPA template.

- **Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.** Kaiser Family Foundation. FY 2015. http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.
  Provides state-by-state information on FMAP rates.